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Nos. 93-115, 93-193, 93-194, 93-210

In The

Supreme Court of the United States

October Term, 1993

NYSA-ILA WELFARE FUND, et al.,

Petitioners,

v.

FRANCES J. DUNSTON, in her capacity as NEW JERSEY COMMISSIONER OF HEALTH, et al.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit*

RESPONDENTS' BRIEF AND APPENDIX IN OPPOSITION TO PETITIONS FOR A WRIT OF CERTIORARI

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NEW JERSEY CARPENTERS WELFARE FUND, et al.,

Petitioners,

v.

FRANCES J. DUNSTON, in her capacity as
NEW JERSEY COMMISSIONER OF HEALTH, et al.,

Respondents.

TRUSTEES OF THE WELFARE TRUST FUND,
LOCAL UNION NO. 475, et al.,

Petitioners,

v.

FRANCES J. DUNSTON, in her capacity as
NEW JERSEY COMMISSIONER OF HEALTH, et al.,

Respondents.

UNITED WIRE, METAL & MACHINE HEALTH
AND WELFARE FUND, et al.,

Petitioners,

v.

MORRISTOWN MEMORIAL HOSPITAL, et al.,

Respondents.

QUESTIONS PRESENTED

1. Did New Jersey's now-repealed system of hospital rate regulation "relate to" employee benefit plans within the meaning of section 514(a) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144(a)? More generally stated, does a state regulatory system that sets the price of hospital care for patients but that does not impose any coverage or reimbursement obligations on third-party payors "relate to" employee benefit plans?

2. Does a state system of hospital rate regulation that folds into the rate structure costs arising from the provision of hospital care to non-paying or underpaying patients result in a compensable "taking" of employee benefit plan property?

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STATEMENT OF THE CASE

I. New Jersey's Former Rate System.

In 1978, the New Jersey Legislature enacted a system of hospital rate regulation to "promote the financial solvency of hospitals . . . and contain the rising costs of health care services." N.J. Stat. Ann. ("N.J.S.A.") 26:2H-1 (amended 1992).* Under this system, the many types of medical procedures performed at hospitals were divided into "diagnostic related groups" ("DRGs"), and a rate assigned to each DRG. The system was designed to penalize hospitals that incurred costs greater than the DRG rate and to reward more efficient hospitals, thereby providing hospitals with an incentive to keep costs down. *See, e.g.*, N.J. Admin. Code ("N.J.A.C.") 8:31B-3.5.

Like most if not all regulatory rate systems, New Jersey's former hospital rate system operated on the premise that the rates should allow efficient members of the regulated industry to recover their reasonable costs of doing business. N.J.A.C. 8:31B-1.1. One cost of doing business as a hospital is the cost of providing care to patients who are unable to pay their bills, a cost known as "uncompensated care." In all states, hospitals incur substantial uncompensated care costs, both because federal law requires hospitals to treat emergency patients regardless of ability to pay, *see* 42 U.S.C. § 1395dd, and because many hospitals, under their internal by-laws and operating procedures, impose similar requirements on themselves. In New Jersey, state law requires all hospitals to

*The New Jersey Statutes referenced herein are reproduced in the Appendix to the Brief in Opposition on behalf of respondent New Jersey Hospital Association.

accept and treat patients regardless of ability to pay. *See* N.J.S.A. 26:2H-18.64; N.J.A.C. 8:43G-5.2(c).

Under the rate system as originally enacted, uncompensated care costs incurred by a particular hospital were borne only by that hospital's patients. Each hospital, therefore, included in its rates a hospital-specific charge for uncompensated care in order to recover its costs in this area. Over time, hospitals providing large amounts of uncompensated care – primarily hospitals located in the state's urban areas – were thus forced to charge higher rates than other hospitals. The resultant disparity in rates threatened the financial viability of New Jersey's inner-city hospitals.

In response to this problem, and to avoid the prospect of large urban areas and populations with no accessible hospital care, New Jersey amended its rate-setting system in 1987 to provide that all hospitals in the state would share equally in the cost of uncompensated care. Under this amendment, all hospital bills were required to include a uniform uncompensated care charge, set annually by the State's Hospital Rate-Setting Commission at a level intended to generate revenues approximating statewide uncompensated care costs. N.J.S.A. 26:2H-18(d) (repealed 1992). The charges collected from all patients and hospitals across the state were then pooled into a fund known as the New Jersey Health Care Trust Fund, and ultimately redistributed back to hospitals according to the amount of uncompensated care provided by them.

Another cost of doing business as a hospital (in some respects a variant of uncompensated care) is the cost of treating patients eligible for Medicare. Under federal law,

hospitals can charge such patients only the amount Medicare pays for the particular treatment. From 1980-1988, the Medicare program participated fully in New Jersey's rate system and accepted the rates established by it. In 1989, however, Medicare began paying hospitals in New Jersey at rates below the state-regulated rate – and, as has been widely acknowledged, below any reasonable measure of the cost of providing care. To enable hospitals to make up for the resultant shortfall in revenues, the state-regulated rate had to be adjusted, and a charge included in all hospital bills to make up for Medicare's below-cost reimbursement rates. *See* N.J.S.A. 26:2H-18(c) (repealed 1992). This charge came to be known, in New Jersey as elsewhere, as the "Medicare cost-shift." *See generally,* Congressional Report C-92-03, "Optional Hospital Payment Rates for Private Payers Based on Medicare's Methods" (March 1992) (detailing the prevalence throughout the United States of Medicare cost-shifts by hospitals).

Another charge built into hospital rates under New Jersey's former rate system related to "payor differentials." Under the operative rate statutes, and in keeping with their underlying purpose of cost-containment, the Hospital Rate Setting Commission was authorized to grant a "differential" (*i.e.,* price discount) to payors providing "quantifiable economic benefits . . . to the health care delivery system taken as a whole." *See* N.J.S.A. 26:2H-18(b) (repealed 1992). Under this provision, differentials were provided to "open enrollment" programs such as Blue Cross/Blue Shield because, by offering open enrollment, such programs reduced (or at least helped to contain) the number of uninsured patients – and, hence,

to contain the uncompensated care costs incurred by hospitals. Blue Cross receives a similar discount in many states. *See generally,* P. Ginsburg, "Hospital Cost Shifting," 310 New England Journal of Medicine 893 (April 1984). Payor differentials were also granted to health maintenance organizations ("HMOs") able to show the achievement of economic benefits through their efforts at "managed care." Hospital patients covered by Blue Cross or HMOs would thus be charged at a discounted rate, and patients not covered by such plans would be charged at a correspondingly higher rate.

New Jersey's former rate system did not dictate that third-party payors cover or be responsible for paying any amount, percentage or portion of hospital bills. Rather, it set the price of hospital care *for patients* in New Jersey. Third-party payors like the petitioning employee benefit plans were, as both a legal and practical matter, free to determine for themselves how much coverage they would provide for their plan members.*

Under the rate system, hospital costs in New Jersey rose steadily, as they did throughout the country during that time period (1978-1993). Data compiled by the American Hospital Association showed, however, that hospital rates in New Jersey during the period of rate regulation were generally lower than in neighboring states. From the

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*This feature of New Jersey's former rate system distinguishes it from the statutory scheme at issue in *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Ass'n,* 771 F. Supp. 771 (E.D.La. 1991), which involved charges imposed directly on ERISA plans, and from other cases that have occasionally arisen under ERISA involving state "mandatory benefits" laws.

record in this case, it cannot be said whether the rate system held the cost of hospital care below what it would have been in the absence of regulation, raised it above what it would otherwise have been, or had no substantial impact at all. Petitioners' repeated assertions that the rate system had a net detrimental economic impact on them is unsubstantiated. *See* Sup.Ct.R. 15.1.

II. The Proceedings Below.

In 1990, despite the fact that hospital rates in New Jersey were then generally lower than rates in nearby states, a number of self-insured employee benefit plans ("the Plans") filed suit in the United States District Court for the District of New Jersey, asserting that the State's rate system was preempted by ERISA. The Plans also asserted that the rate system resulted in a taking of their property without just compensation, and constituted an unlawful tax.

With respect to their preemption claim, the Plans contended that, because rates promulgated under the regulatory scheme included charges for uncompensated care, the Medicare cost-shift and payor differentials, plan administrators were effectively being compelled to divert plan resources to the benefit of non-beneficiaries, in direct violation of their fiduciary obligations under ERISA. In response, the State asserted that the challenged charges represented bona fide components of a regulated rate and thus did not constitute a diversion of plan assets, and that the rate system did not "relate to" ERISA plans but rather set the price of hospital care for patients.

In the District Court, all parties moved for summary judgment, and on May 27, 1992, the court (Hon. Alfred Wolin, U.S.D.J.) issued a decision holding in the Plans' favor on their preemption claim. In its decision, the District Court found that New Jersey's rate system related to employee benefit plans because it forced them "to structure benefits in a particular manner and subject[ed] the benefit plans to inconsistent regulations" from one state to another (80a).* The court rejected the Plans' constitutional arguments (85a).

The District Court thereafter entered an order enjoining the State and hospitals in the state from enforcing the contested rate statutes against the Plans. Surprisingly, the District Court also enjoined enforcement of the rate statutes against plan *beneficiaries*, because in the District Court's expansive view ERISA not only precluded the State from imposing the disputed charges against employee benefit *plans* (the rate system imposed no such charge), but also precluded it from imposing the charges against patients who happened to be enrolled in such plans (the rate system did impose such a charge, against *all* patients) (*See*, Appendix to this Brief).

On June 24, 1992, before the District Court's order took effect, the United States Court of Appeals for the

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*The District Court was unable to support this holding with a citation to any provision of state law requiring employee benefit plans to structure their benefits in any specified manner. Petitioners are likewise unable to do so anywhere in the four petitions they have filed. No such provision exists. (Appendix citations are to the appendix filed by petitioner NYSA-ILA Welfare Fund.)

Third Circuit issued a stay pending appeal. On appeal, in an opinion dated May 14, 1993, the Third Circuit reversed. The Third Circuit rejected the District Court's unsupported conclusion that New Jersey's rate system "force[d] employee benefit plans to structure benefits in a particular manner" (80a), and noted that, to the contrary, "New Jersey's scheme does not direct ERISA plans to structure their benefits or conduct their internal affairs in any particular way." (26a-27a). The Court of Appeals acknowledged that the rate system, by setting the price of hospital care in New Jersey, had an economic impact on employee benefit plans, but concluded that such an impact did not necessitate or justify a finding of preemption under the applicable decisions of this Court (26a).

With respect to the plans' contention that the rate system compelled them to divert plan assets to non-beneficiaries, the Third Circuit noted that this argument, if accepted, would give rise to a duty on the part of plan administrators to " 'look through' the pricing structure of every health care provider to assure that the price of the services rendered a particular patient directly correlates with the cost of those services." (31a). Such a duty, the court continued, would prove a practical impossibility in view of the "many forms of state regulation . . . which result in increases in the cost of [hospitals'] doing business." (31a). The court therefore concluded that Congress did not intend to impose such a duty on plan administrators, just as it never intended, through ERISA, to preempt states from exercising their traditional far-reaching regulatory powers over hospitals (32a).

Summarizing its preemption holding, the court concluded that New Jersey's former rate system was a

> generally applicable law which (1) is not intended to regulate the affairs of ERISA plans, (2) neither singles out such plans for special treatment nor predicates rights or obligations on the existence of an ERISA plan, and (3) does not have the effect of either dictating or restricting the manner in which ERISA plans structure or conduct their affairs or the effect of impairing their ability to operate simultaneously in more than one state. We have found no case that has held such a law to be preempted . . . and we decline to so hold. [30a].

The Third Circuit also rejected the Plans' "takings" arguments (22a). Applying the standards of *Penn Central Transportation Co. v. City of New York*, 438 U.S. 104 (1978), the court found that the rate system did not interfere with the plans' investment-backed expectations, but merely adjusted "the benefits and burdens of economic life to promote the common good." *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 225 (1986).

In dissent, Judge Nygaard wrote that the case "tests the outer limits of ERISA preemption" (32a), but that he would affirm the District Court's judgment. Judge Nygaard was persuaded that a preemptive "relation" between the rate system and ERISA plans existed because the rate system, as all parties acknowledged, would not be viable if ERISA plans and their beneficiaries were excluded from it.

III. New Jersey's Deregulation of Hospital Rates.

During the time that this matter was before the Third Circuit, New Jersey abolished its hospital rate system,

which had been politically controversial from its outset, and deregulated hospital rates. 1992 N.J. Laws, c.160. In an attempt to avoid the price volatility and disruptions that might otherwise arise with deregulation, the Legislature imposed one-year revenue caps on all hospitals, but as of January 1, 1993, the rate system that is the subject of this case ceased to exist.

Although this development rendered the Plans' claims for prospective relief moot, it did not render moot their attempt to avoid responsibility for paying hospital bills issued to their plan members during the pendency of the action – a responsibility, it bears repeating, imposed upon them by their own governing plan instruments, not by the rate system. The Third Circuit accordingly proceeded to decide the appeal before it (22a).

REASONS FOR DENYING THE WRIT

I. Summary of Argument.

In urging the Court to grant certiorari, petitioners assert that the opinion below conflicts with applicable ERISA decisions of this Court and other circuits. This assertion does not withstand scrutiny. The opinion below adheres to settled principles of preemption law, reaches a result that accords with this Court's ERISA decisions, and expressly follows the one other Court of Appeals decision to address a similar issue, *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985) (upholding New York's hospital rate system against an ERISA challenge).

Petitioners correctly maintain that this Court, in its recent ERISA decisions, has reaffirmed that ERISA's pre-emptive scope is broad, *see, e.g., FMC Corp. v. Holliday,* 498 U.S. 52, 58 (1990), but this uncontroversial point was not lost on the court below. The Court of Appeals recognized that the legal inquiry did not end there, however, since it remains true under recent decisions that ERISA's preemptive reach, though broad, is not without limits, and that state laws of general applicability having only a tenuous, remote or peripheral connection with employee benefit plans are not preempted. *District of Columbia v. Greater Washington Board of Trade,* 113 S.Ct. 580, 583 (1992); *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 33, 39 (1990).

Although petitioners cast themselves as defenders of this Court's ERISA jurisprudence, the result they seek to achieve is far outside the domain of established law. Petitioners' central thesis – which they understandably choose not to state in express terms – is that ERISA precludes states from engaging in hospital rate regulation. Thus, at the same time that petitioners assert that ERISA provides a federal exemption from New Jersey's rate system for their plan beneficiaries, they also acknowledge, and even stress, that any hospital rate system that excluded patients covered by employee benefit plans from its scope would, as a practical matter, be unworkable. *See, e.g.,* Petition of United Wire, Metal & Machine Health and Welfare Fund at 21-22.

As is clear on a moment's reflection, if the latter point is true (and it quite clearly is), it follows that ERISA effectively prohibits states from engaging in hospital rate regulation. *Cf. Travelers Inc. Co. v. Cuomo,* 813 F.Supp. 996,

1006 (S.D.N.Y. 1993) *appeal pending* (holding New York's hospital rate system to be preempted; the court acknowledged that, under its legal analysis, it would follow that "ERISA preempts all state hospital rate-setting statutes.") From a public policy standpoint, such a result might or might not be beneficial (the data from New Jersey are inconclusive), but from a legal standpoint there is no reason to think that Congress intended to achieve that result when it enacted ERISA. To the contrary, Congress has consistently encouraged state efforts to contain health care costs. *See, e.g.*, 42 U.S.C. § 1395ww(6)(1) (authorizing the Secretary of Health and Human Services to waive Medicare's rate schedule and to participate in state "hospital reimbursement control systems").

Petitioners' underlying thesis is not only at odds with Congressional intent, but rests on a legal paradox. Under clearly established law, any state system of hospital rate regulation that purported to *exclude* employee benefit plans and their beneficiaries from its scope would be flatly preempted. *Mackey v. Lanier Collection Agency & Services, Inc.*, 486 U.S. 825 (1988) (Georgia garnishment statute providing exemption for employee benefit plans "related to" such plans and was preempted). If petitioners' position were upheld, therefore, ERISA would prevent states from including *or* excluding plan beneficiaries from a rate-setting system – which is again to say that states could not engage in rate regulation at all.

The Court of Appeals did not depart from established law in rejecting petitioners' boundless interpretation of ERISA. The decision below comports with the applicable precedents of this Court, presents no conflict with any other circuit court decision, and is sound on its

own merits. With the repeal of the rate system, any arguable "special and important reasons" that might once have existed to warrant this Court's involvement have vanished, Sup.Ct.R. 10, and the petitions for certiorari should accordingly be denied.

II. The Decision Below Represents a Correct Application of Settled ERISA Law and Is Not in Conflict With the Law of Any Other Circuit.

A. ERISA Preemption Standards.

ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). In determining whether a state law "relates to" employee benefit plans under the statute, "as in any preemption analysis 'the purpose of Congress is the ultimate touchstone.' " *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)).

Congress' purpose in enacting ERISA was "to safeguard employees from the abuse and mismanagement of [employee benefit] funds." *Massachusetts v. Morash*, 490 U.S. 107, 112 (1989). To effectuate this purpose, ERISA imposes uniform federal standards on reporting, disclosure and fiduciary responsibility, 29 U.S.C. §§ 1021-1031, 1101-14, but a state law need not intrude upon these specific subject areas to be preempted, nor need its relation to employee benefit plans be direct or express. *FMC Corp. v. Holliday*, 498 U.S. 52, 58-59 (1990). Rather, a state law "relates to" employee benefit plans if, within the "broad common-sense meaning of that

phrase," it "has a connection with or reference to" such plans. *Ingersoll-Rand, supra,* 498 U.S. at 39; *see also Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 47 (1987).

On the other hand, a state law that has only a "tenuous, remote or peripheral connection with covered plans . . . as is the case with many laws of general applicability" will not be preempted. *District of Columbia v. Greater Washington Board of Trade,* 113 S.Ct. 580, 583 n.1 (1992); *Ingersoll-Rand, supra,* 498 U.S. at 39 (generally applicable statutes that make no reference to or function irrespective of benefit plans not preempted). Preemption follows only if a state law relates to employee benefit *plans,* moreover. *Fort Halifax Packing Company, Inc. v. Coyne,* 482 U.S. 1, 8 (1987) ("Congress' choice of language is significant" in that it preempts only laws that relate to plans); *Ingersoll-Rand, supra,* 480 U.S. at 39 ("only state laws that relate to benefit plans are preempted"); *cf. Alessi v. Raybestos-Manhattan, Inc.,* 451 U.S. 504, 523 (1981) (Congress, in enacting ERISA, "meant to establish pension plan regulation as exclusively a federal concern").

B. Discussion.

The decision below represents a straightforward application of these settled legal standards. The Court of Appeals examined each asserted connection between the Plans and the rate statutes, and rightly concluded that, under the ERISA decisions of this Court, none of them established the requisite preemptive "relation." In so holding, the court was guided not only by the decisions of this Court (24a-26a), but also by the one other Court of Appeals decision to address an ERISA challenge to a

state system of hospital rate regulation, *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985).

As they did below, petitioners vigorously assert that *Rebaldo* is no longer good law because it pre-dates this Court's decisions in *FMC Corp.* and *Ingersoll-Rand Co.*, and because certain passages from the Second Circuit's opinion take a narrower view of ERISA's preemptive scope than the Court espoused in those later cases. The court below, however, was careful to limit its reliance on *Rebaldo* to those portions of the opinion that remain legally sound. In particular, the court below embraced the observation made in *Rebaldo* that a finding of preemption cannot be based on the mere fact that a state statute or regulation affects a plan's "cost of doing business" since many (if not all) types of state regulations have such an effect. 749 F.2d at 138-39. In making that observation, the Second Circuit was not announcing a new or controversial rule of law; it was stating a plain fact, and nothing in the ERISA cases that have been decided since *Rebaldo* erodes the Second Circuit's wholly logical reasoning on this score. *Accord Lane v. Goren*, 743 F.2d 1337, 1340 (9th Cir. 1984) (state statutes prohibiting employment discrimination not preempted despite the fact that such laws, like laws "regulating zoning, health and safety, increase the operational costs of ERISA trusts").

Another intrinsically sound aspect of the *Rebaldo* opinion is its recognition that whether or not states engage in rate regulation, hospitalization costs will always vary from state to state and that, in consequence, statutes that merely set the price of hospital care within a given state cannot be said to subject ERISA plans to

inconsistent local regulation. 749 F.2d at 139. Petitioners are unable to point to any flaw in this syllogism, but assert that New Jersey's rate statutes did more than set the price of hospital care because it imposed a "disproportionate" share of certain costs on ERISA plans. Thus, petitioners inveigh that, in the last years of the rate system, ERISA plan participants constituted only 15% of New Jersey's hospital patients but were assessed with 40% of the challenged "cost shifts."

Although plausible on its face, petitioners' "disproportionality" argument turns out, on examination, to be an exercise in statistical sophistry. The seeming inequity of the distribution of the costs shifts evaporates when it is recalled that the largest of the "cost shifts" – by far – related to uncompensated care, *i.e.*, care rendered to nonpaying or underpaying patients. By definition, such patients (who unfortunately constitute a substantial portion of the total patient population themselves) will not bear their "proportional" share of costs; rather they will *cause* hospitals to have to seek to recover those costs from all other patients, thus *creating* a "disproportionate" load for those patients.

To the extent petitioners' "disproportionality" argument does more than reflect the fact that hospitals in New Jersey, as in other states, incur substantial uncompensated care costs, it is still lacking in force. The "cost shift" that arose from Medicare's below-market reimbursement rates was as much a product of federal law as it was of New Jersey's rate system, and petitioners provide no support for the notion that Congress intended ERISA plan participants, alone among non-Medicare patients, to be exempted from such costs. Likewise, the challenged

"cost shift" relating to payor differentials resulted in no true "disproportion," since such differentials were granted only on the basis of demonstrated economies benefiting the hospital system as a whole. Nothing in the record suggests any gross disparity between the size of the payor differentials and the benefits bestowed.

Petitioners' aspersive descriptions of the challenged "cost shifts" notwithstanding, *see, e.g.*, NYSA-ILA Petition at 7-8,* each of the charges in question corresponded to a real cost of doing business as a hospital, and consequently each of the charges was a legitimate component of a regulated hospital rate. That being so, petitioners' preemption argument amounts to a claim that, through ERISA, Congress has given plan administrators unilateral power (or, as the Court of Appeals put it, a duty) to determine for themselves and their plan beneficiaries what constitutes a "reasonable" hospital bill. Unpersuasive as this contention is on first blush, it becomes even less attractive when one considers that, were it to be upheld, federal courts would become the arbiters of everyday billing disputes between ERISA plan members and healthcare practitioners, and would have to develop

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*Petitioners' oft-repeated assertion that New Jersey's rate system was deliberately designed to target ERISA funds and to discriminate against employee benefit plans is more than aspersive; it is false. *See* Sup.Ct.R. 15.1. Since the rate system imposed no coverage obligations on ERISA plans (or any other third-party payors), it was fundamentally incapable of "discriminating" against them in the fashion complained of; perhaps more to the point, petitioners are unable to show any respect in which ERISA plans or their beneficiaries were treated less favorably than ordinary commercial insurers and their beneficiaries.

a new body of federal common law to resolve such disputes.*

While the powers bestowed upon plan administrators under ERISA are broad, they convey no license to "mark down" hospital bills on behalf of plan members. *Rebaldo, supra,* 749 F.2d at 138-139 (rejecting the idea that ERISA plans lead a "charmed existence"). They *do* encompass a power to structure plan benefits to cover so much – or so little – of members' hospital bills as may be deemed desirable, but New Jersey's former rate statutes did not trammel upon or in any way limit that power. *Compare Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 739 (1985) (mandatory benefits law "related to" employee benefit plans, but was not preempted as to insurance companies selling policies to plans); *FMC Corp. v. Holliday, supra* (anti-subrogation law preempted because it dictated how plans had to structure benefits.)

Petitioners' assertion that New Jersey's former rate statutes made express "reference" to employee benefit plans is even less compelling than their exaggerated claims of "discrimination." The *only* reference to ERISA plans in the rate statutes was contained in a provision imposing a duty on hospitals to ascertain whether a prospective patient had any form of medical coverage.

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*This would be true, it should be noted, even in states where hospital rates are not subject to state regulation. Throughout the country, the right of hospitals and doctors to collect on their bills is governed by state law, and whether that law derives from a statute or case law it "relates" to ERISA plans in exactly the same fashion and to the same extent as New Jersey's former rate laws – which is to say indirectly and peripherally.

N.J.S.A. 26:2H-18.31 (expired 1992). That provision required hospitals to

> inquire of the patient . . . whether the patient is covered by health insurance, and if so shall require documentation . . . Documentation may include a government sponsored health plan card or number, a group sponsored or direct subscription health plan card or number, a commercial identification card or claim form or a *union welfare plan identification card or claim form.* [Emphasis added.]

The obvious, and salutary, purpose of this provision was to ensure that hospitals took reasonable steps to keep their uncompensated care costs to a minimum. For petitioners, who complain so loudly about the growth of uncompensated care costs, to suggest simultaneously that the above provision ran afoul of ERISA is, to say the least, perplexing. Petitioners surely do not maintain that hospitals are prohibited by ERISA from ascertaining whether patients have some form of medical coverage, and yet they seem to be saying that hospital officials should be required to preface patient interviews with a warning to the effect of, "Under no circumstances should you tell me if you belong to a union benefit plan." Since such a disclaimer would *still* involve a "reference" to ERISA plans (at least as petitioners construe that term), the Court of Appeals did well to reject this odd contention, and broke no new legal ground in doing so. *See Pilot Life*

Ins. Co. v. Dedeaux, supra, 481 U.S. at 47 (ERISA's preemptive language should be given "its broad *common-sense* meaning"; emphasis added).*

In the final analysis, the only true "relation" between employee benefit plans and the challenged rate system is that, by setting the price of hospital care in New Jersey, the rate system had an undeniable, albeit indeterminate, economic impact on employee benefit plans. No decision by this Court has held that such an impact alone results in preemption. Petitioners assert that the Fifth Circuit has found economic impact to be sufficient to establish a preemptive "relation" in *E-Systems, Inc. v. Pogue,* 929 F.2d 1100 (5th Cir.), *cert. denied,* 116 L.Ed.2d 610 (1991), but that case involved a tax imposed specifically on persons rendering services to any "employer-employee . . . health benefit plan." Thus, the statute's relation to benefit plans was not merely economic, and was anything but "tenuous" and "peripheral"; to the contrary, it was direct and practically *exclusive.*

Petitioners also seize upon dicta from *Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.,* 947 F.2d 1341 (8th Cir. 1991), *cert. denied,* 112 S.Ct. 2305 (1992), in

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*The "reference" to employee benefit plans contained in the New Jersey Department of Health's policy statement regarding patient appeals again merely lists employee benefit plans as one possible form of third-party coverage. The policy statement (which was not itself part of the statutory rate scheme) merely recognized, as an incontrovertible fact, that employee benefit plans are a common type of third-party payor. That petitioners construe ERISA's preemptive language to mean that this fact must never be acknowledged in writing by state officials demonstrates the artificiality of their position.

an attempt to generate a conflict between the Eighth Circuit and the court below. In that case, the Eighth Circuit questioned – as the Fifth Circuit had done before it, *see Somers Drug Stores v. Corrigan Enterprises Inc.*, 793 F.2d 1456, 1467 (5th Cir. 1986) – whether the fact that a state law falls within the state's traditional police powers has any legal relevance in ERISA preemption disputes. 947 F.2d at 1350. The court left the question hanging, although it allowed that "this factor is arguably a policy consideration useful in deciding borderline" ERISA cases. *Id.*

If the Fifth Circuit or Eighth Circuit ever chose to formalize their speculative views on this rather fine point of ERISA law in a legal holding, a genuine conflict among the circuits would clearly exist. *Compare, e.g., Aetna Ins. Co. v. Borges*, 869 F.2d 142, 144 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989) (observing, in an ERISA case, "we must assume 'that the historic police powers of the State were not to be superseded . . . unless that was the clear and manifest purpose of Congress' "; quoting *Ray v. Atlan. Richfield Co.*, 435 U.S. 988, 994 (1978)). It seems doubtful that a genuine conflict on this point will ever arise, however, since this Court has made perfectly clear that, in addressing questions of preemption under ERISA – as under any other federal statute – the Court "must presume that Congress did not intend to preempt areas of traditional State regulation." *Metropolitan Life Ins. Co. v. Massachusetts, supra*, 471 U.S. at 740 (1985). This negative presumption is bottomed on basic precepts of federal-state comity; thus, for instance, in *Fort Halifax Packing Co. v. Coyne, supra*, the Court wrote:

> ERISA pre-emption analysis 'must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.' [482 U.S. at 19, *quoting Alessi v. Raybestos-Manhattan, Inc*, 451 U.S. 504, 522 (1982)].

It is true, as the Eighth Circuit observed in *Arkansas Blue Cross, supra,* that the Court has not invoked this canon of statutory construction in its most recent ERISA decisions. Given the extensive body of ERISA law on which the Court is now writing, there would seem little need. Neither the Third Circuit nor any other Court of Appeals would be at liberty to assume that, by the omission, the Court has implicitly overruled its earlier decisions, *Rodriguez DeQuijas v. Shearson/American Express, Inc.*, 490 U.S. 477, 484 (1989), and no reason exists to think that it has.

The applicable decisions of this Court and of other circuits establish that where, as here, a regulatory scheme has an indirect economic impact on ERISA plans, a number of considerations must be taken into account to determine if the scheme is preempted. Those considerations include whether the law in question involves an exercise of traditional state police powers, *Metropolitan Life, supra,* as well as whether it interferes with the administration of ERISA plans, or mandates that they provide a particular type or level of benefit, or subjects them to inconsistent regulation. *See, e.g., Aetna Life Ins. Co. v. Borges, supra,* 869 F.2d at 145-146 (surveying ERISA cases and noting that Congress "could not possibly have meant to preempt all laws having any impact on plans, no matter how small or how tangential"). The Court of Appeals examined each of these relevant criteria, and

concluded that they did not support a finding of preemption. The court's legal analysis and conclusion were consistent with and faithful to existing law, and its rejection of petitioners' overreaching contention that ERISA precludes state regulation of hospital rates presents no reason for further review by this Court.

III. The Court of Appeals' Holding That New Jersey's Hospital Rate-setting System Does Not Result in a Compensable "Taking" of the Plans' Property Presents No Questions Requiring Review by This Court.

The NYSA-ILA Plan, alone among petitioners, seeks review of the Court of Appeals' affirmance of the District Court's dismissal of the Plans' "takings" claim. The Court of Appeals' decision on this point represents a sound and even elementary application of established law, and does not remotely meet any of the criteria for issuance of a writ of certiorari.

Outside the area of "physical" takings, a three-prong test determines whether a compensable taking has occurred. Under that test, courts must examine the character of the governmental action involved, the economic impact of that action on the claimant, and the extent to which it has interfered with the claimant's "distinct investment-backed expectations." *Penn Central Transportation Co. v. City of New York*, 438 U.S. 104, 124 (1978).

The challenged governmental action here is the inclusion of certain "indirect" costs in regulated hospital rates. The costs in question, while indirect, are true costs incurred by hospitals and, in providing for them to be

spread among all hospitals and hospital patients, New Jersey's rate system sought merely to adjust "the benefits and burdens of economic life to promote the common good." *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 223 (1986). The economic impact of New Jersey's rate system upon the Plans, as has been noted, is indeterminate since hospital rates in New Jersey under the system were roughly in line with, but somewhat lower than, rates in nearby states. Clearly, though, the system did not interfere with the Plans' "investment-backed expectations." The Plans exist in order to pay the medical bills of their beneficiaries, and have never had a reason to think that their beneficiaries occupy a special status among hospital patients exempting them from charges borne by other patients. The Court of Appeals' rejection of Petitioners' unmeritorious takings argument thus needs no attention from this Court.

CONCLUSION

For the foregoing reasons, the petitions for writ of certiorari should be denied.

Respectfully submitted,

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BENJAMIN CLARKE
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Dated: September 29, 1993

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

UNITED WIRE, METAL & MACHINE HEALTH AND WELFARE FUND, et al.,	Civil Action No. 90-2639 (Consolidated)
Plaintiffs,	AMENDED ORDER
v.	(Filed June 4, 1992)
MORRISTOWN MEMORIAL HOSPITAL, et al.,	
Defendants.	

The Court hereby amends its Order dated May 27, 1992 as follows:

It is on this 4th day of June, 1992,

ORDERED, that the state defendants are permanently enjoined from enforcing the provisions stated in its May 27, 1992 order as to participants in ERISA plans only.

/s/ Alfred M. Wolin
ALFRED M. WOLIN, U.S.D.J.